



David Ochterlony Dyce Sombre  
painted by Charles Brocky

## BRIEF REVIEW

# THE MYSTERIOUS ILLNESS OF DYCE SOMBRE

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## ABSTRACT

The alleged “madness” of the Anglo-Indian prince known as Dyce Sombre (1808–1851) has been attributed to anti-Asian prejudice, biased observations, and insensitivity to ethno-cultural variations in behavior. However, whereas all these factors may have contributed to misdiagnosis and mistreatment, there is compelling evidence pointing to an “organic” explanation for Dyce Sombre’s aberrant behavior. We posit that the interaction of drug toxicity and possible central nervous system infection were primarily responsible for Dyce Sombre’s clinical symptoms. The case provides an important lesson for modern-day psychiatrists confronting patients from other cultures who may also have underlying neuropsychiatric disorders.

## A BRIEF HISTORY OF DYCE SOMBRE

David Ochterlony Dyce Sombre (1808–1851) was an Anglo-Indian prince of mixed European and Indian ancestry who lost his kingdom but inherited a vast fortune. Though raised in India, Sombre eventually settled in England and married the daughter of an English Viscount. In 1841, Sombre became the first person of Asian descent to be elected to the British Parliament; however, his

election was annulled one year later, on charges of corruption. Sombre’s fortune then went from bad to worse. He developed the belief—most likely, a delusion—that his wife had been unfaithful with various men, including her own father, the eminent Viscount St Vincent. In addition, Sombre challenged many dignitaries, including the famous Duke of Wellington, to duels. Sombre’s unorthodox lifestyle, frequent bouts of drinking and gambling, and flouting of Victorian norms all buttressed the notion that he was “mad.” His dark-skinned, Asiatic appearance, as well as his obesity, probably contributed to the public animus directed against Dyce Sombre. Indeed, one can read his life’s story as an example of how cultural, racial, and ethnic prejudice can result in spurious charges of “insanity” and unwarranted confinement. (Ultimately, Sombre escaped from his warders and fled England for freedom in France).

Sombre’s story may also serve as an indictment of 19th century psychiatry’s arbitrary and often contradictory methods of assessment and diagnosis—a charge that some would also level at modern-day psychiatry. For example, whereas Dyce Sombre was judged to be a “lunatic” by nine court-appointed English physicians, forty-five European physicians—including the distinguished French

psychiatrist, Jean-Pierre Falret (1794-1870)—concluded that he was quite sane and “a proper gentleman!”<sup>1</sup>

## LUNATIC, ECCENTRIC, ADDICT, OR SICK?

There is little doubt that ethno-racial prejudice and the stringent cultural norms of Victorian England contributed to the unfortunate treatment (and mistreatment) of Dyce Sombre. Moreover, even some who considered Sombre to be “sane” based their conclusion on erroneous or stereotypical assumptions concerning norms and mores in South Asian culture.<sup>1</sup> However, in our view, the neuropsychiatric elements of Dyce Sombre’s case render the picture far more complicated. In the first place, Sombre’s aberrant beliefs and behaviors extended well beyond his insistence that his wife had been unfaithful. According to contemporary records and reports, for example, Sombre (in a fit of jealous rage) had challenged his own wife to a duel, assaulted his landlady, shaved off his eyebrows, and engaged in frequent public urination and defecation. Moreover, he described engaging in “battles with spirits,” and once was frightened by “spirits” that had ordered him to kill a cat in a particular way, eat his own feces, and commit various other antisocial acts.<sup>1</sup>

Sombre was known to have engaged the services of numerous prostitutes and was diagnosed with unspecified “venereal diseases.” (The distinction between syphilis and gonorrhea was just being appreciated in the late 1830s, and the two conditions were often conflated prior to that time). Late in his life, Sombre apparently

developed cognitive difficulties. Thus, in 1848, he was reportedly unable to recognize his own wife (at least initially), after an absence of five years. By 1850, Sombre had difficulty concentrating on his favorite pastime—solving mathematical puzzles—and also seems to have developed reduced temperature sensation in his feet. (Following a night of binge drinking, he passed out before a blazing fire and blistered the soles of his feet, eventually developing a life-threatening streptococcal infection).



**FIGURE 1.** The Areca nut (pictured right) is the seed of the Areca palm (*Areca catechu*) (pictured above), which grows in much of the tropical Pacific, Asia, and parts of east Africa. The nuts are commonly referred to as “betel nuts,” as they are often chewed wrapped in betel leaves, a vine belonging to the Piperaceae family, which includes pepper and Kava.



Sombre, for many years, had been ingesting a plethora of patent medicines or prescribed nostrums, some probably aimed at treating his well-documented venereal disease. He was said to have self-medicated frequently with “Morrison’s pills,” which contained a powerful purgative, *Citrullus colocynthis*; indulged frequently in “morphia, opium, brandy, and liqueurs” (according to his wife); and received mercury from various physicians, probably as a treatment for his venereal disease.<sup>1</sup> Moreover, in 1845, a Belgian physician (Dr.

Jean Francois Vleminckx) noted that Sombre regularly consumed large quantities of betel nuts (*Areca catechu*) (Figure 1)—not an uncommon practice in several Asian countries, but apparently carried to an extreme in Sombre’s case. Betel nuts are usually consumed, in low doses, to induce feelings of well-being, alertness, and stamina. However, in large amounts, betel nuts may induce euphoria, acute psychosis, dependence, and withdrawal. The withdrawal syndrome itself may provoke anger, irritability, anxiety, and dysphoria.<sup>2-4</sup>

The psychoactive properties of betel nuts are thought to be due primarily to the main betel alkaloid, arecoline. This compound has potent muscarinic cholinergic activity, inhibits the reuptake of gamma-aminobutyric acid (GABA), and stimulates release of catecholamines, including dopamine.<sup>2-4</sup> From this very heterogeneous profile, one would expect a mixture of stimulant and sedative effects during acute intoxication, with quite variable features during withdrawal periods. It seems plausible that some of the

marked variability in Dyce Sombre’s behavior and mentation was a consequence of fluctuations in his level of consciousness, owing to alternating betel nut toxicity and withdrawal.

(Curiously, some recent reports actually find that individuals with schizophrenia may show some reduction in positive symptoms with use of betel nuts, perhaps owing to a favorable shift in the ratio of acetylcholine to dopamine).<sup>5</sup>

In Sombre’s case, concurrent abuse of opiates and alcohol would probably have added another layer

of intoxication and withdrawal effects to those owing to betel nut consumption. In addition, Sombre's exposure to mercury-based "medicines" may have produced something akin to the "Mad Hatter" syndrome, originally seen in felt hat workers exposed to mercuric nitrate.<sup>6</sup> Mercurial poisoning ("erethism") is often said to produce a psychiatric picture of "excessive timidity"—hardly a trait one would ascribe to Dyce Sombre—but the victim may also suffer from "a pathological fear of ridicule" and "explosive loss of temper when criticized."<sup>6</sup> One can easily see how the latter features might apply to Sombre. Finally, it is plausible—though speculative—that the gradual onset of tertiary syphilis with its accompanying loss of sensation in the extremities (tabes dorsalis) also contributed to Dyce's neuropsychiatric deterioration.<sup>7</sup>

## CONCLUSION

We acknowledge the difficulties of piecing together a coherent neuropsychiatric differential diagnosis across a vast cultural and temporal divide—based largely on reports from parties with dubious motives and vested interests. Consequently, conclusions regarding Sombre's diagnosis and sanity must

be carefully qualified, and it is unlikely (barring an exhumation) that we will ever know the precise etiology of Sombre's psychiatric problems. Nevertheless, we believe that many of Sombre's symptoms and behaviors may be partly explained by a variety of synergistic toxic and "organic" factors.

To this day, covert metabolic disorders and central nervous system infections are often overlooked in evaluating patients with "psychiatric" symptoms.<sup>8</sup> At the same time, a failure to appreciate cultural diversity, linguistic differences, and "culture shock" among recent immigrants may contribute to misdiagnosis in psychiatry.<sup>9</sup> Thus, Dyce Sombre's case is more than a curiosity in the annals of neuropsychiatric diagnosis. It is also a cautionary tale on several levels for modern-day psychiatrists and neurologists.

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